

Patient Information Sheet
Ophthalmology-Specializing in Glaucoma
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Ronald Freeman, M.D.

Date _____ Age _____ Gender _____ SS# _____ DL# _____

Name _____ DOB _____ Marital Status: M S W D

Address: _____ City _____ State _____ Zip _____

Best Contact # _____ Home Phone # _____ Work # _____

Employer _____ Address: _____

Pharmacy Name _____ Location _____

Emergency Contact _____ Phone # _____

Referring Physician _____

Primary Physician _____

Optometrist/Ophthalmologist _____

Insurance Carrier _____ Referral Needed: Y N Copay Amt: \$ _____

Through which employer _____

Insured Name _____ DOB of Insured _____

Secondary Insurance _____ Referral Needed: Y N Copay Amt: \$ _____

Through which employer _____ DOB of Insured _____

I authorize the release of any medical records necessary to process any claims I may incur and assign The North Shore Glaucoma Center all of my rights, title and interest to my medical reimbursement benefits under my insurance policy/policies for services rendered to me. I agree that I am financially responsible for incurred charges resulting from my medical care from The North Shore Glaucoma Center and their physicians. Should any unpaid balance remain on the account after being billed past 90 days there will be an additional 5% monthly interest charge added to the account. (Unless prior arrangements have been made with our office manager)

Patient's signature: _____ Date: _____

Medical History

	Yes	No		Yes	No
<u>Neurologic</u>			<u>Kidney/Urinary</u>		
Headaches	___	___	Kidney disease	___	___
Stroke	___	___	Urinary tract infection	___	___
Loss of consciousness	___	___	Urinary bleeding	___	___
Epilepsy/seizures	___	___	<u>Endocrine</u>		
Brain tumor	___	___	Thyroid disorder	___	___
Imbalance	___	___	Diabetes	___	___
Paralysis/weakness of arms or legs	___	___	<u>Respiratory</u>		
Persistent numbness/ Tingling	___	___	Asthma	___	___
Sudden/severe loss of vision	___	___	Pneumonia	___	___
Double vision	___	___	Emphysema	___	___
<u>Heart/Circulatory</u>			<u>Musculo/Skeletal</u>		
Heart attack/failure	___	___	Arthritis	___	___
High blood pressure	___	___	Bone fractures	___	___
Irregular heartbeat	___	___	<u>Blood/Lymphatics</u>		
Heart murmur	___	___	Anemia	___	___
<u>Allergy/Immuno</u>			Leukemia	___	___
Respiratory allergies	___	___	Bleeding disorder	___	___
Tuberculosis	___	___	Clotting disorder	___	___
Persistent fever	___	___	<u>Gastrointestinal</u>		
AIDS/HIV	___	___	Diarrhea	___	___
Venereal disease	___	___	Constipation	___	___
			Ulcers	___	___
			<u>Skin</u>		
			Skin tumor	___	___
			Persistent rash	___	___

Other Diseases Not Listed

Current Eye Medications

Oral Medications

Ophthalmic History Past and Present

<u>Family Ocular History</u>	Yes	No		Yes	No
Glaucoma	___	___	Diabetes	___	___
Macular Degenerations	___	___	Cataract	___	___
Retinal Detachment	___	___	Blindness	___	___
Thyroid Disease	___	___	“Lazy Eye”	___	___
“Cross-Eyed”	___	___	Hypertension	___	___

Past Surgeries & Dates

Allergies to Medications

Social History:

Do you smoke? _____
If yes, how much? _____
Do you drink? _____
If yes, how much? _____